# ADULT FOSTER CARE

## RESIDENT APPLICATION

APPLICANT:_____

ADDRESS:_____

CITY:_____STATE:_____ZIP:_____

BIRTH DATE:_____SOCIAL SECURITY NO.:_____

MEDICARE NO._____MEDICAID NO:_____

RELIGIOUS PREFERENCE:_____

RESPONSIBLE PERSON:_____

ADDRESS:_____

CITY:_____STATE:_____ZIP:_____

TELEPHONE NO. (HOME)_____(WORK):_____

IN CASE OF EMERGENCY FIRST CALL:_____

OTHER CONCERNS:_____

_____

_____

_____

MEDICAL INFORMATION

IS THERE A SPECIAL DIET?_____

_____

TAKES MEDICATION: YES ( ) NO ( )

**(IMPORTANT NOTE: The foster care provider may not administer medications to the resident. He or she may assist resident to take medication as described in ARM 37.100.151)**

**RESIDENT APPLICATION (PAGE 2)**

TYPE OF MEDICATION (S):_____

_____

KNOWN ALLERGIES:_____

_____

APPLICANT IS SUBJECT TO:

| | | |
|---|---|---|
| HEADACHES | YES ( ) | NO ( ) |
| DIZZINESS | YES ( ) | NO ( ) |
| CONSTIPATION | YES ( ) | NO ( ) |
| INCONTINENCE | YES ( ) | NO ( ) |
| LACK OF BOWEL CONTROL | YES ( ) | NO ( ) |

CURRENT MEDICAL STATUS:_____

_____

_____

DOCTOR'S NAME:_____

DOCTOR'S PHONE NO.:_____

DOCTOR'S ASSESSMENT RECEIVED:_____

DATE OF ADMISSION:_____

PREFERRED HOSPITAL:_____

_____

Signature of Person Completing Application Relationship to Resident

_____

Date